

## ARIZONA BENEFIT OPTIONS

### SUMMARY OF GROUP HEALTH COVERED SERVICES AND EXPENSES

*This document is a summary of covered services and expenses. Complete coverage descriptions, restrictions and medical requirements are available in the Plan Description. In case of any conflict between this summary and the Plan Description, the Plan Description shall govern. It is important to remember all inpatient services and specific out-patient services may require pre-authorization in order to receive benefits under the plan. Please contact your Plan Administrator for any questions.*

	EPO	PPO	
		In-Network	Out of Network
Deductible per participant per Plan Year	None	None	\$300
Deductible per family per Plan Year	None	None	\$600
Maximum out-of-pocket per participant per Plan Year, subject to limitations.	None	\$1,000	\$3,000
Maximum out-of-pocket per family per Plan Year, subject to limitations.	None	\$2,000	\$6,000
Semi-Private Room and Board (private room only when medically necessary) <sup>1</sup>	No charge	No charge	70% coverage after deductible
Intensive Care Unit	No charge	No charge	70% coverage after deductible
Physician Visits (inpatient)	No charge	No charge	70% coverage after deductible
Chiropractic & Osteopathic Includes all spinal manipulation or treatment, regardless of provider type. Limited to 20 visits per participant per Plan Year subject to medical necessity.	\$10 copay	\$10 copay	70% coverage after deductible
Surgery/Anesthesia/Asst Surgeon (inpatient)	No charge	No charge	70% coverage after deductible
X-ray and Laboratory (inpatient)	No charge	No charge	70% coverage after deductible
Mental/Nervous Substance Abuse (inpatient)	No charge	No charge	70% coverage after deductible
Physician Office Visits (one copay per day per provider)	\$10 copay	\$10 copay	70% coverage after deductible

<sup>1</sup> If a facility has no semi-private rooms, the plan will only pay 90% of a private room rate, unless the private room is medically necessary.

	EPO	PPO	
		In-Network	Out of Network
Periodic Physical Exam (Age 0-1: 4 visits; Age 2 and over: 1 per participant per Plan Year and \$250 per participant per Plan Year.)	\$10 copay	\$10 copay	70% coverage after deductible
Adult Immunizations (i.e. Pneumoc, flu)	\$10 copay	\$10 copay	70% coverage after deductible
Well Man Care (Office visit, PSA, blood test)	\$10 copay	\$10 copay	70% coverage after deductible
Allergy Testing	\$10 copay	\$10 copay	70% coverage after deductible
Antigen Administration Desensitization/Treatment	\$10 copay	\$10 copay	70% coverage after deductible
<b>Family Planning Services</b>			
Voluntary Tubal Ligation (outpatient facility)	No charge	No charge	70% coverage after deductible
Vasectomy or Implantable Contraceptive Products (one per every 5 years)	\$10 copay	\$10 copay	
Contraceptive Appliances (obtained at a physicians office)	\$10 copay	\$10 copay	70% coverage after deductible
Infertility Visits (subject to medical necessity)	\$20 copay	\$20 copay	70% coverage after deductible
Infertility Treatment (subject to medical necessity- see Plan Description for list of specific exclusions)	50% coinsurance	50% coinsurance	50% coinsurance after deductible
X-ray and Laboratory (outpatient)	No charge	No charge	70% coverage after deductible
Prenatal Care and Program	\$10 copay for initial diagnosis, no charge thereafter	\$10 copay for initial diagnosis, no charge thereafter	70% coverage after deductible
Mammography Screening (Age 35-39: one baseline; Age 40-49: every 2 years; Age 50 and above: annually)	No charge	No charge	70% coverage after deductible
<b>Surgery Facility and Physician's Fees</b>			
In physician's office	\$10 copay	\$10 copay	70% coverage after deductible
In freestanding ambulatory facility	No charge	No charge	
In hospital/outpatient surgical center	No charge	No charge	
Outpatient Mental/Nervous	\$10 copay	\$10 copay	70% coverage after deductible
Outpatient Substance Abuse	\$10 copay	\$10 copay	70% coverage after deductible

	<b>EPO</b>	<b>PPO</b>	
		<b>In-Network</b>	<b>Out of Network</b>
Emergency Room (must be emergency)	\$75 (waived if admitted)	\$75 (waived if admitted)	\$75 (waived if admitted)
Out of Area Emergencies (must be emergency)	\$75 (waived if admitted)	\$75 (waived if admitted)	\$75 (waived if admitted)
Urgent Care Center	\$20 copay	\$20 copay	70% coverage after deductible
Ambulance (for medical emergency or required inter-facility transport)	No charge	No charge	No charge
Non-emergency ambulance transportation with pre-authorization	No charge	No charge	70% coverage after deductible
Rehabilitation Services, Short-Term, limited to 60 visits per participant per Plan Year, additional visits subject to medical necessity. Includes: Physical therapy, Occupational therapy, Speech therapy, Respiratory therapy, and certain Cardiac therapy.	\$10 copay per visit	\$10 copay per visit	70% coverage after deductible
Skilled Nursing Facility/Rehabilitation Hospital, or sub-acute facilities. 90 day limit per participant per Plan Year.	No charge	No charge	70% coverage after deductible
Home Health/Home Infusion Care- No limit	No charge	No charge	70% coverage after deductible
Organ and Tissue Transplantation & Donor Coverage. No coverage if member or eligible dependent is a donor. Travel expenses are limited to \$10,000 per transplant.	No charge	No charge	70% coverage after deductible
Hospice Care/Inpatient Facility or home hospice for life expectancy of 6 months or less.	No charge	No charge	70% coverage after deductible
Durable Medical Equipment (DME)—must be medically necessary.	No charge	No charge	70% coverage after deductible
Corrective Appliances—must be medically necessary, to include orthotics and prosthetics.	No charge	No charge	70% coverage after deductible

	EPO	PPO	
		In-Network	Out of Network
Hearing Aids—limited to \$2,000 per participant per Plan Year	No charge	No charge	70% coverage after deductible
Hearing Exam—one per participant per Plan Year	\$10 copay	\$10 copay	70% coverage after deductible
Diabetic Supplies at participating pharmacy	\$10 copay	\$10 copay	Not covered
Metabolic Supplements limited to \$5000 per participant per Plan Year	50% coinsurance	50% coinsurance	50% coverage after deductible
<b>Retail Prescriptions</b> Generic Formulary Preferred Non-Formulary Brand	\$10 copay <sup>3</sup> \$20 copay \$40 copay	\$10 copay <sup>3</sup> \$20 copay \$40 copay	Not covered <sup>3</sup>
<b>Mail Order Prescriptions (90 day supply)</b> Generic Formulary Preferred Non-Formulary Brand	\$20 copay <sup>4</sup> \$40 copay \$80 copay	\$20 copay <sup>4</sup> \$40 copay \$80 copay	Not covered <sup>4</sup>

<sup>3</sup> All retail prescriptions must be filled through a Walgreens Health Initiatives network pharmacy.

<sup>4</sup> All mail order prescriptions must be filled through the Walgreens Healthcare Plus mail order program.

***Additional information on certain covered services or some services with limitations are shown below. This is a summary of common services for your information and other services with limited benefits are outlined in the Plan Description, which will be available after Open Enrollment.***

Accidental Dental Services- Dental services for the treatment of a fractured jaw or an injury to sound natural teeth. Services must begin within six (6) months of the accident.

Ambulance Services- Ambulance services to/from an appropriate provider or facility.

Breast Reconstruction and Breast Prostheses- Surgical services for reconstruction due to mastectomy; for reconstruction to produce symmetrical appearance; breast prostheses; and bras/camisoles and external prosthetics. During all stages of mastectomy, treatments of physical complications, including lymphedema, are covered.

Cancer Clinical Trials- Treatment is part of a scientific study of a new therapy or intervention that is being conducted at an institution within the State of Arizona or as approved by the plan administrator; provided as part of a study being conducted in a phase I, phase II, phase III, or phase IV cancer clinical trial; treatment is approved by plan administrator according to Plan Description requirements; treatment is administered by provider according to Plan Description requirements; there is no clearly superior, non-investigational treatment alternative; program satisfies requirements of Plan Description; and patient cost is restricted according to Plan Description.

Chiropractic Care Services- Diagnostic and treatment services provided in an office setting by participating chiropractic Physicians and Osteopaths. **Excluded** are services of a chiropractor or osteopath which are not within his scope of practice, as defined by State law; charges for care not provided in an office setting; maintenance, long-term services for prevention of reoccurrences; vitamin therapy.

Cosmetic Surgery- Reconstructive surgery that constitutes necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

Diabetic Service and Supplies- Coverage will be provided for medically necessary supplies, devices, and appliances including test strips; insulin preparations; glucagons; insulin cartridges; blood glucose monitors; coverage as required under Medicare; charges for training by a physician as outlined in the Plan Description.

Durable Medical Equipment- Purchase or rental of durable medical equipment that is ordered or prescribed by a participating physician and provided by a vendor approved by the plan. Coverage for repair, replacement or duplicate equipment is not covered except when replacement or revision is necessary due to growth or a change in medical condition. Covered equipment includes, but is not limited to, crutches, hospital beds, wheel chairs, respirators, and dialysis machines.

Erectile Dysfunction- Medical diagnostic services to determine the cause of erectile dysfunction. Penile implants are covered when you have an established medical condition that clearly causes erectile dysfunction, such as postoperative prostatectomy and diabetes. Psychogenic erectile dysfunction does not warrant coverage for penile implants.

External Prosthetic Appliances- The initial purchase and fitting of external prosthetic devices which are used as a replacement or substitute for a missing body part and are necessary for the alleviation or correction of illness, injury or congenital defect. Biomechanical devices or replacement due to wear and tear, loss, theft or destruction are **excluded**.

Family Planning Services- Covered family planning services include physical history and exam; related laboratory tests; information and counseling on contraception; implanted/injected contraceptives; services connected with surgical therapies (vasectomy or tubal ligation).

Home Health Services- Covered home health services include skilled care; ambulatory outpatient services; and non-required confinement in a hospital or other health care facility.

Hospice- Hospice care services which are provided under an approved hospice care program when provided to a member who has been diagnosed by a participating physician as having a terminal illness with a prognosis of six (6) months or less to live. **Excluded** services include services of a family member who normally resides in your home; services to curative or life prolonging procedures; services for custodial care; vitamins, minerals, or other nutritional supplements.

Infertility Services- Services related to diagnosis of infertility and treatment of infertility of the member or member's spouse once a condition of infertility has been diagnosed. **Excluded** services include infertility drugs; in-vitro fertilization; gamet or zygote intrafallopian transfer; reversal of voluntary sterilization; cryopreservation of donor sperm and eggs; or experimental or investigational therapies. Coinsurance is applicable up to a \$1,000 annual out-of-pocket maximum.

Inpatient Services at Other Health Care Facilities- Services including semi-private room and board; skilled and general nursing services; physician visits; physiotherapy; speech therapy; occupational therapy; x-rays; and administration of drugs, medications, biologicals, and fluids.

Internal Prosthetic/Medical Appliances- Internal prosthetic/medical appliances that are permanent or temporary internal aids and supports for non-functional body parts, including testicular implants following medically necessary surgical removal of the testicles.

Laboratory and Radiology Services- Radiation therapy and other diagnostic and therapeutic radiological procedures.

Mammograms- Covered mammograms for routine and diagnostic breast cancer screening as a single baseline; once every two (2) years; annually; or as recommended by your physician.

Maternity Care Services- Medical, surgical and hospital care during the term of pregnancy, upon delivery and during the postpartum period for normal delivery, spontaneous abortion (miscarriage), elective early termination of pregnancy, and complications of pregnancy.

Mental Health and Substance Abuse Services- Services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. Substance abuse is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment.

Inpatient Mental Health Services - Services that are provided by a participating hospital for the treatment and evaluation of mental health.

Orthotics- Services provided for diabetic conditions only, subject to medical necessity.

Outpatient Mental Health Services- Services of participating providers who are qualified to treat mental health when treatment is provided on an outpatient basis in an individual, group or structured group therapy program.

Prosthetics- Specific limitations apply.

Inpatient Substance Abuse Rehabilitation Services - Services provided by a facility designated by the Plan for rehabilitation when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs.

Outpatient Substance Abuse Rehabilitation Services - Services for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs including outpatient rehabilitation in an individual, group, structured group or intensive outpatient structured therapy program.

Substance Abuse Detoxification Services- Detoxification and related medical ancillary services when required for the diagnosis and treatment of addiction to alcohol and/or drugs, and medication management when provided in conjunction with a consultation.

**Excluded Mental Health and Substance Abuse Services**- Please see Plan Description for excluded services.

Medical Foods- Medical foods will be covered to treat inherited metabolic disorders. The Plan will cover up to 50% of the cost of medical foods prescribed to treat inherited metabolic disorders covered under the Plan Description. There is a maximum annual limit for medical foods of \$5,000 which applies to the cost of all prescribed modified low protein foods and metabolic formula.

Nutritional Evaluation- Nutritional evaluation and counseling from a participating provider when diet is a part of the medical management of a documented organic disease, including morbid obesity.

Obstetrical and Gynecological Services- Obstetrical and gynecological services are covered as provided by qualified participating providers for pregnancy, well-woman gynecological exams, primary and preventive gynecological care and acute gynecological conditions.

Organ Transplant Services- Human organ and tissue transplant services at designated facilities throughout the United States. This coverage is subject to the conditions and limitations contained in the Plan Description.

Organ Transplant Travel Services- Travel expenses incurred by a member in connection with a pre-approved organ/tissue transplant are covered subject to the conditions and limitations contained in the Plan Description.

Oxygen and Oxygen Delivery Systems- Oxygen is covered when used on an outpatient basis, limited to coverage within the service area except on an emergency basis.

Periodic Health Examinations- Covered examinations include vision and hearing screenings provided by a primary care physician according to the schedule listed in the Plan Description. Age 0-1 year, 1 exam every 4 months; age 2 and over, 1 exam per participant per Plan Year limited to \$250 per participant per Plan Year.

Short-term Rehabilitation Therapy- Short-term rehabilitative therapy that is part of a rehabilitation program, including physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate inpatient or outpatient setting. Limitations are outlined in the Plan Description. If multiple services are provided on the same day, they constitute one visit, but a separate copayment will apply to each participating provider.

Temporomandibular Joint Syndrome (TMJ)- Benefits are payable for covered services and supplies which are necessary to treat TMJ. Covered expenses include services or supplies that are recognized by the medical or dental profession as effective and appropriate treatment for TMJ. Refer to the Plan Description for additional information.

Vision and Hearing Screenings for Dependents- Vision and hearing screenings are covered, provided the member is an eligible dependent under the age of 19.

**ARIZONA BENEFIT OPTIONS**  
**SUMMARY OF GROUP HEALTH EXCLUSIONS**

***For a complete list and description of exclusions, please refer to the Plan Description, which will be available after Open Enrollment.***

- Charges for services filed with the plan administrator beyond the timely filing period.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for health conditions that are required by state or local law to be treated in a public facility.
- Treatment of an illness or injury, due to war, declared or undeclared.
- Charges for which the member was not obligated to pay or for which he/she is not billed or would not have been billed except that they were covered under the plan.
- Assistance in the activities of daily living, including, but not limited to, eating, bathing, dressing or other custodial or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- Any services and supplies which are experimental, investigational or unproven.
- Cosmetic surgery or surgical procedures primarily for the purpose of altering appearance, except for necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.
- Orthognatic treatment/surgery, including but not limited to treatment/surgery for mandibular or maxillary prognathism, micropraghanthis, or malocclusion, surgical augmentation for orthodontics, or maxillary construction.
- Dental treatment of teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, peridontics, casts, splints and services for dental malocclusion, for any condition. Treatment for accidental injury will be covered as outlined by the plan description.
- Medical and surgical services intended primarily for the treatment or control of obesity which are not deemed medically necessary.
- Reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
- Court ordered treatment or hospitalization.
- Reversal of voluntary sterilization procedures.
- Transsexual surgery.
- Treatment of erectile dysfunction unless as outlined by the plan description.
- Medical and hospital care and costs for the infant child of a dependent.
- Non-medical ancillary services including, but not limited to, vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety, and services, training or educational therapy for learning disabilities, developmental delays, autism or mental retardation.
- Therapy to improve general physical conditions including, but not limited to, routine, long term or non-medically necessary chiropractic care and rehabilitative services which are provided to reduce potential risk factors where significant therapeutic improvement is not expected.
- Consumable medical supplies, including but not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the plan description.
- Private hospital rooms and/or private duty nursing unless determined to be medically necessary.
- Personal or comfort items such as television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of illness or injury.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures, and wigs, except as outlined in the plan description.
- Eyeglass frames, lenses, or contact lenses; routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Treatment by acupuncture.
- All non-injectable prescription drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in the plan description.
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails unless medically necessary.
- Membership costs or fees associated with health clubs, weight loss programs, and smoking cessation programs.

- Amniocentesis, ultrasound, or any other procedures solely for the gender determination of a fetus, unless medically necessary to determine the existence of a gender-linked genetic disorder.
- Services rendered by a midwife for the purpose of home delivery.
- Genetic testing and therapy including germ line and somatic unless determined medically necessary by the Plan.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of schedule surgery as outlined in the plan.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks unless medically necessary or indicated.
- Cosmetics, dietary supplements, nutritional formula (except for treatment of malabsorption syndromes), and health and beauty aids.
- Expenses incurred for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
- Massage therapy, health spas, mineral baths, or saunas.
- Phase-Three Cardiac rehabilitation services (maintenance program).

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